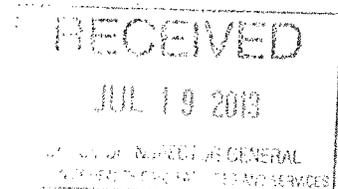
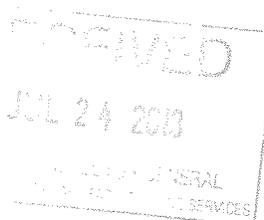


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R 06/13/2013
NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 520}	Continued From page 13 06/01/13. On 06/03/13, the audit revealed there were ten (10) residents that utilized oxygen equipment. Eight (8) of ten (10) residents' oxygen equipment was not stored in a bag as indicated by the Plan of Correction and policy. The other two (2) were presently being used by the residents.  Interview with the ADON, on 06/13/13 at 5:05 PM, revealed she had identified ongoing non-compliance through the audits. After reviewing the weekly audits conducted on 05/20/13 and 05/27/13, the ADON acknowledged compliance with oxygen equipment storage had not been achieved. She stated at that time the oxygen equipment was replaced with new tubing, face mask, or nasal cannula and a read and sign document was posted in the employee's break room. However, interview revealed this was the same "on the spot" inservice information that was provided to the staff during the all staff training conducted 05/16-30/13. Interview with the ADON further revealed only two (2) staff had read and signed the posted re-education information. Continued interview with the ADON revealed she was responsible for reviewing the audits for oxygen equipment, but she could not provide what oversight she had provided to achieve compliance other than reviewing the audits.  Interview with the Administrator, on 06/13/13 at 9:30 AM, revealed the facility had conducted a QA meeting, on 05/23/13, prior to the alleged compliance date and developed a plan of action to correct all non-compliance. The Administrator revealed the Medical Director had been involved with the POC and had attended the QA meeting to develop the POC. He was not aware what the	{F 520}	audits by the administrator. QAAC is involved in the education of the staff, including the VPN and administration, by assessing and approving educational offerings to be utilized in the facility. The effectiveness of the educational offerings will be measured by the QAAC on a monthly basis. Failure to meet set objectives will initiate action by the QAAC to provide additional educational opportunities for appropriate staff members. This educational process will be directed via management by objective processes. The administrator reviews audits for F328 4-times a week. The first audit review was completed on 7/3/2013.		



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{F 520}	Continued From page 14 F328 audits showed because the ADON had not informed him of any problems. Per interview, the facility had a QA meeting scheduled for the following week to review all audits to determine if any non-compliance still existed and to ensure ongoing compliance with all cited tags.  Interview with the Vice President of Nursing, on 06/13/13 at 4:32 PM, revealed she was responsible for the oversight of the Plan of Correction to ensure the plan was implemented and compliance achieved. This included the oversight of the ADON's Implementation of the Plan of Correction. Further interview revealed the ADON was responsible for the audits and update her. She stated the audits for oxygen equipment showed continued non-compliance with equipment not being stored properly in the plastic bags.	{F 520}			

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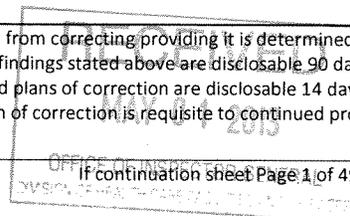
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Amended 04/17/13</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1976</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was initiated on 03/19/13 and concluded on 03/20/13. Wesley Manor Nursing Center was found to be not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>JERRY L. Hoganson</i>	TITLE  <b>Administrator</b>	(X8) DATE  <b>5-1-2013</b>
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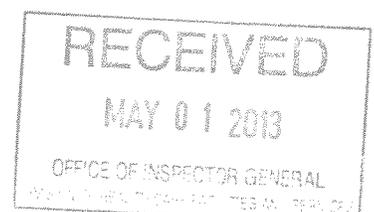
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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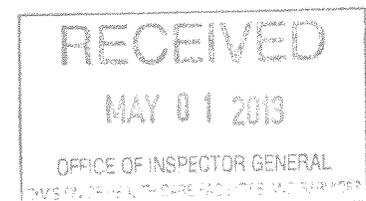
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NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>		
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K 000	Continued From page 1 Fire). The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 011 SS=D	NFFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the common wall with a nonconforming building was in accordance with NFFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) the day of the survey. The facility failed to ensure the fire wall and fire door separating the certified facility from the personal care facility had a rated wall	K 011	<u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> The wall and accompanying door were inspected by a licensed architect on April 4, 2013. The architect was Phil Gayhart, AIA. Dadisman Builder's replaced the wall with a fire-rated type and replaced the doors with 2-hour fire resistance rating or greater. <u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u> Any resident residing on the Peter's Wing has equal chance of being affected by this deficiency. <u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u> Since upgrading the wall and replacing the doors is a permanent improvement to a fixed asset, this violation cannot recur.  <i>continued</i>	5-5-13 5-2-13 per g... by PB 5-1-13



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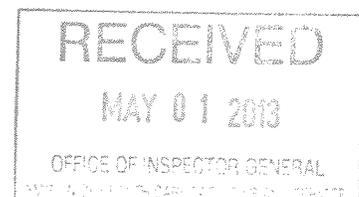
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>	
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K 011	Continued From page 2 and door.  The findings include:  Observation, on 03/19/13 at 9:59 AM, with the Maintenance Director revealed the fire barrier wall located in the Tunnel West Hall separating the Skilled Nursing Facility from the Personal Care Facility, had a steel door and frame that was not rated. Further observation revealed the fire walls rating could not be verified. There was no access above the ceiling.  Interview, on 03/19/13 at 9:59 AM, with the Maintenance Director revealed he was unaware the door did not have a rating, and was not sure of the fire walls construction materials.  Reference: NFPA 101 (2000 edition)  18.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 18.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 18.1.1.4.2 Communicating openings in dividing fire barriers required by 18.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 18.1.1.4.3 Doors in barriers required by 18.1.1.4.1 shall	K 011	<u>How the facility plans to monitor its performance to ensure that the solutions are sustained:</u> The repair/upgrade made to this area of the facility will be reported to the Quality Assurance committee at its April 25, 2013 meeting. The Director of Maintenance has been given an NFPA manual for reference to ensure that this deficient practice and other potential areas meet NFPA requirements. This was provided to the Director of Maintenance on March 21, 2013 by the Director of Operations. As NFPA educational offerings become available, the Director of Maintenance will be attending any inservices or conferences that are available, appropriate, and related to NFPA requirements. <u>Person responsible for this correction:</u> Director of Maintenance	



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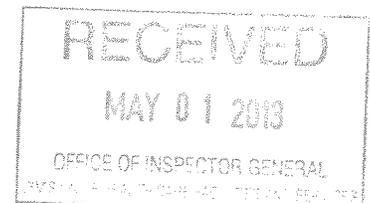
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K 011	Continued From page 3 normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 18.2.2.2.6.  8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.	K 011		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	<u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> The door latches to rooms #N5, N8, and W9 were repaired and/or adjusted on April 1, 2013 so that they latch properly. <u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u> All resident rooms have the potential to be affected by this deficient practice.	5-5-13 5-2-13 <i>Jan J. Johnson</i> by PB 5-1-13



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K 018	<p>Continued From page 4</p> <p>the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to ensure doors to resident rooms would latch.</p> <p>The findings include:</p> <p>Observation, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed the corridor doors to rooms # N5, N8, and W9 would not latch when tested.</p>	K 018	<p><u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u></p> <p>All doors in the facility will be tested on a monthly by the Director of Maintenance to ensure that they latch properly.</p> <p><u>How the facility plans to monitor its performance to ensure that the solutions are sustained:</u></p> <p>Any doors not latching properly will be repaired or locksets replaced by the maintenance department when identified as not working properly. The relative effectiveness of this procedure will be reported to the Quality Assurance Committee on a quarterly basis.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance.</p>



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K 018 Continued From page 5  
Interview, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed he was not aware the doors would not latch.

K 018

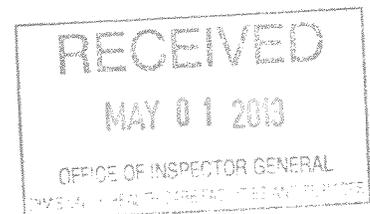
Reference: NFPA 101 (2000 edition)

19.3.6.3.1\* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.

Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.

Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.

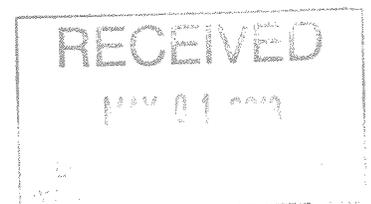
19.3.6.3.2\* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller



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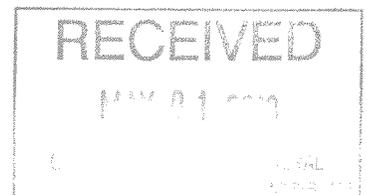
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K 018  K 025 SS=F	<p>Continued From page 6</p> <p>latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 03/19/13 between 9:00 AM and 10:10 AM, with the Maintenance Director</p>	K 018  K 025	<p><u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u></p> <p>All smoke barriers were inspected by the Dir. of Maintenance on 3/25/2013 and any penetrations will be filled with material rated equal to or higher than partitions by April 29, 2013. One specific contractor was contacted via letter on April 10, 2013 to instruct them to always see any holes they make with material at least equal to the rating of the partition. A corresponding policy was written on 4/9/13 to assist the maintenance department in the administration of this policy. The administrator educated the maintenance depart. Regarding this policy</p> <p><u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u></p> <p>All residents in the facility are identified as being equally at risk from this deficient practice.</p> <p><u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u></p> <p>The filling of the penetrations with rated material will ensure that current residents are safe. The letter to the contractor and the new policy direction will ensure that the violation does not recur. All penetrations will be filled on or before April 29, 2013</p> <p><u>How the facility plans to monitor its performance to ensure that the solutions are sustained:</u></p> <p>5-2-13</p>



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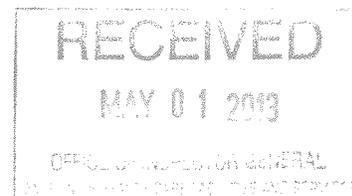
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESLEY MANOR NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5012 EAST MANSLICK RD LOUISVILLE, KY 40219</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 025	<p>Continued From page 7</p> <p>revealed the smoke barriers, extending above the ceiling had penetrations of pipes, wires, and the use of unrated material. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The locations of the penetrations are as follows:</p> <ol style="list-style-type: none"> <li>1) Penetration around a pipe located in the Hunt Hall.</li> <li>2) Penetrations around wires located in the Slider Hall.</li> <li>3) Penetrations around sprinkler pipes, other pipes and wires, and the use of expandable foam to seal penetrations located in the Peters Wing.</li> <li>4) Penetration around the sprinkler pipe located in the South Hall.</li> </ol> <p>Interview, on 03/19/13 between 9:00 AM and 10:10 AM, with the Maintenance Director revealed he was not aware of the penetrations or the use of the unrated foam.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> </ol>	K 025	<p>A report on these repairs and accompanying procedural changes will be reported to the Quality Assurance Committee at its April 25, 2013 meeting. At each quarterly meeting thereafter, the Director of Operation will report to the committee the continued compliance with this procedure.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance</p>



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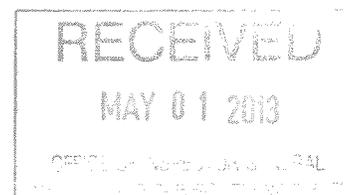
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K 025	Continued From page 8 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	
K 029 SS=D	NFWA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The	K 029	<u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> Self-closing devices for the doors for the Medical Records Office and the Clean Linen Room have been purchased and will be installed by April 29, 2013 <u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u> All residents in the facility are identified as being affected equally by this deficient practice. <u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u> The installation of these devices will ensure that the violation does not recur. The Director of Maintenance is knowledgeable of the requirement to have self-closing devices on all doors in the facility. The Director of Maintenance has received the NFPA manual  5-5-13- 5-2-13 KJH J. Horgan KJPB 5-1-13



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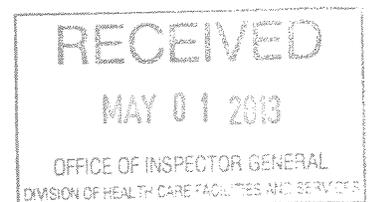
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K 029	<p>Continued From page 9</p> <p>deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The rooms identified as hazardous requiring a self-closing device were the Medical Records Office, and the Clean Linen Room located in the Peters Hall.</p> <p>Interview, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed he was not aware the doors to these rooms were required to be self-closing.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p>	K 029	<p>and was instructed by the Director of Operations to refer to the manual as needed on March 22, 2013.</p> <p><u>How the facility plans to monitor its performance to ensure that the solutions are sustained:</u></p> <p>The Director of Maintenance will inspect all doors in the facility on a monthly basis to ensure proper functioning. A report of the inspection will be provided to the QA committee on a quarterly basis.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance.</p>



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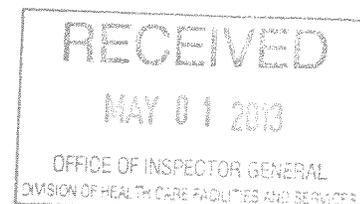
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K 029	Continued From page 10 Reference:  NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	



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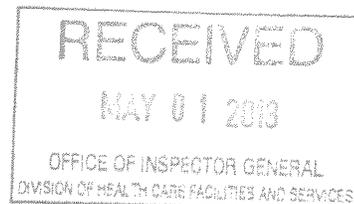
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K 038 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had proper signage, exits had a durable surface to the public way, and doors or gates would unlock with the activation of the fire alarm or sprinkler system.</p> <p>The findings include:</p> <p>Observation, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed the egress signage located throughout the facility did not have letters 1 " high with a contrasting background. The letters were only 3/8 " high. Further observation revealed the exit door located in the Hunt Hall private dining room had two (2) locks, and would not release with the activation of the fire alarm or sprinkler system. Further</p>	K 038	<p><u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> Signs with 1" high letters and greater than 1/8" stroke have been purchased and installed on April 15, 2013 for all locations where needed (see attachment of sign design). The lock to the Peters Courtyard gate has been removed and staff are now instructed to supervise any residents using the courtyard area so as to prevent resident elopement. The lock on the exterior door of the Hunt Hall dining room has been removed (March 23, 2013). The paved sidewalk was not installed due to the new fire doors and wall in place on the opposite end of the fire compartment. (no longer needed). <u>How other residents/patients having the potential to be affected by the same deficient practice will be identified:</u> All residents residing in the facility have the same potential to be affected by the deficient practice. All exterior doors were inspected by the administrator on April 8, 2013 for compliance with this requirement. All other doors meet this regulation. <u>Specific measures utilized to ensure the violation will not recur:</u> Installation of the new signs, and removal of the padlock on the gate, will ensure the violation (s) does/do not recur. <u>Person responsible for this correction:</u> Director of Maintenance.</p> <p>5-5-13- 5-2-13 by J. Hyman by P.B. 6/1/13</p>



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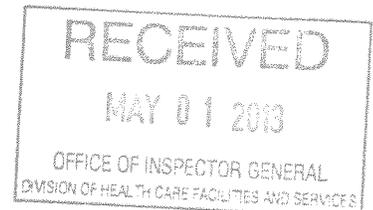
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K 038	<p>Continued From page 12</p> <p>observation revealed the gate located in the Peters Courtyard across the durable surface to the public way was padlocked. A key was located in a locked holder at the gate; however only one (1) out of three (3) staff questioned knew the combination to retrieve the key to the padlock. Further observation revealed the exit located in the Tunnel West Hall did not have a durable surface to the public way.</p> <p>Interview, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed he was unaware of egress requirements.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat</p>	K 038	



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K 038	Continued From page 13 detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system inaccordance with Section 9.6.  (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.  (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS  7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT	K 038		



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K 038 Continued From page 14

Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.

7.5.2.2\* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors.

Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit.

Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met:

(a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress.

(b) They are installed across an opening that is at least 6 ft (1.8 m) in width.

(c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.

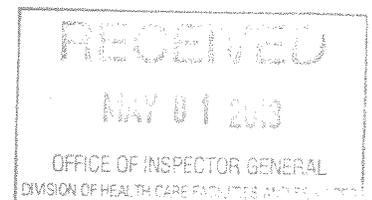
Reference: NFPA 101 (2000 edition)

7.1.10.1\* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.

7.7.1\* Exits shall terminate directly at a public

K 038



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**K 038** Continued From page 15  
way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.  
Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.  
Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.  
Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.

**K 038**

**K 045**  
**SS=E**  
Reference: CMS S&C letter 5-38  
**NFPA 101 LIFE SAFETY CODE STANDARD**  
Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

**K 045**

Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:  
Fixtures will be installed or modified to provide required illumination outside of these doors used for exit discharge. An electrician is scheduled to complete this work on 4/24/13. The Director of Maintenance scheduled the licensed electrician.  
How other residents/patients are identified as having the potential to be affected by this deficient practice:  
All residents in the facility are equally affected by this deficient practice.  
Measures put into place or systematic changes made to ensure the deficient practice does not recur:  
All exterior means of egress were inspected by the Dir. of Maintenance on 3/29/13 to assess compliance with this requirement. The installation/modification of these lights

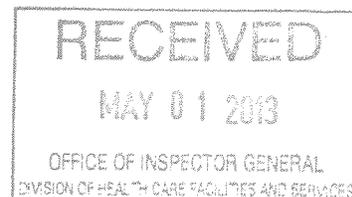
5-5-13

5-2-13

*Jan G. Horgan*

*by PB 5/1/13*

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.



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K 045 Continued From page 16

The findings include:

Observation, on 03/20/13 at 10:40 AM, with the Maintenance Director revealed the exits located in the Peters Wing Living Room, Peters Hall Exit, and the West Hall Tunnel Exit did not have a light installed outside to provide the required illumination for exit discharge.

Interview, on 03/20/13 at 10:40 AM, with the Maintenance Director revealed he was not aware the exits did not have the required illumination for egress lighting.

Reference: NFPA 101 (2000 Edition)

19.2.8 Illumination of Means of Egress.  
Means of egress shall be illuminated in accordance with Section 7.8.

7.8 ILLUMINATION OF MEANS OF EGRESS

7.8.1 General.

7.8.1.1\*

Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps,

K 045

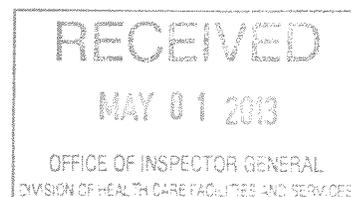
will provide adequate illumination so that the violation does not recur. The Dir. of Maintenance has educated himself regarding this requirement by reading the NFPA manual on March 29, 2013.

How the facility plans to monitor its performance to ensure that the solutions are sustained:

All lights for external means of egress are inspected monthly by the facility's maintenance department. The results of the monthly inspections are reported to the QA committee, and the QA committee makes changes to the PM schedule when warranted.

Person responsible for this correction:

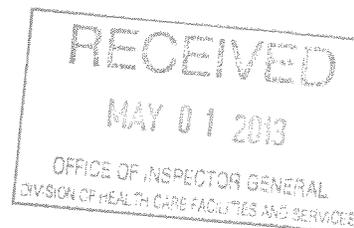
Director of Maintenance



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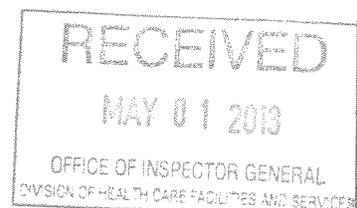
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K 045	Continued From page 17 escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD	K 046		



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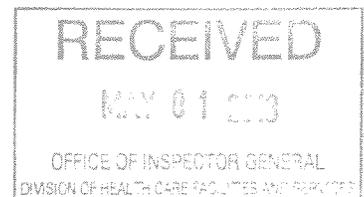
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K 046 SS=F	<p>Continued From page 18</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to test emergency battery lighting for 30 seconds monthly and 90 minutes annually.</p> <p>The findings include:</p> <p>Observation, on 03/19/13 at 11:09 AM, with the Maintenance Director revealed the facility did not have documentation for monthly testing, or the annual testing of emergency battery lighting located in the facility.</p> <p>Interview, on 03/19/13 at 11:09 AM, with the Maintenance Director revealed he was not aware documentation was to be kept on emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10</p>	K 046	<p><u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> Emergency testing of the battery lighting system began on 3/22/13 by the maintenance department, a log was created, and documentation will remain on file in the maintenance director's office.</p> <p><u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u> All residents in the facility are equally affected by this deficient practice.</p> <p><u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u> The inspection of the battery lighting will be included in the preventive maintenance program.</p> <p><u>Specific measures utilized to ensure the violation will not recur:</u> Monthly testing and documentation will ensure that the lights are functional and that the violation will not recur. The Director of Maintenance was instructed on 4/22/13 by the administrator regarding the need to be compliant and with this requirement and has referenced this requirement in the NFPA manual. This requirement is being reported to the QA committee at it's 4/25/13 meeting for further recommendations if needed.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance</p> <p>5-5-13 5-2-13 by PB 5-1-13</p>



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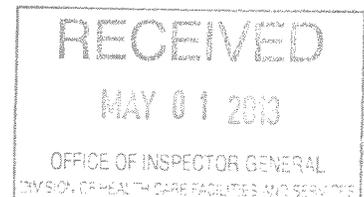
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K 046	Continued From page 19 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.  7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	K 050	<u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> Fire drills are conducted quarterly on each shift and at times that are unexpected on each shift beginning April, 2013. Times of the drills are recorded per newly updated policy, which was effective April 9, 2013. The Dir. of Maintenance was educated by the administrator re: this requirement and referenced the NFPA manual on 4/9/13.	5-5-13 5-2-13 <i>ring of [signature]</i> by [signature] 5-1-13



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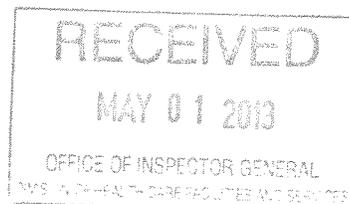
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K 050	<p>Continued From page 20 announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on all shifts.</p> <p>The findings include:</p> <p>Fire Drill review, on 03/19/13 at 10:50 AM, with the Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on all shifts.</p> <p>Interview, on 03/19/13 at 10:50 AM, with the Maintenance Director revealed he was not aware the fire drills were not being conducted as required.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied</p>	K 050	<p><u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u> All residents in the facility are equally affected by this deficient practice. <u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u> Following the policy will ensure that violations do not recur. Dates and times of the fire drills are reported to the QA committee at its monthly meetings, with the QA committee making recommendations for modifications to the process when warranted. <u>Person responsible for this correction:</u> Director of Maintenance</p>



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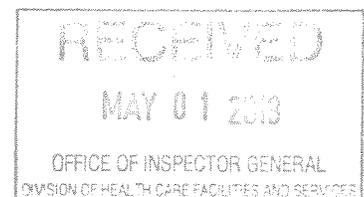
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K 050	<p>Continued From page 21 conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p>	K 050	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056	



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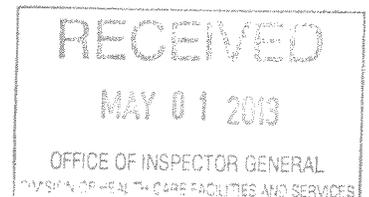
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K 056 SS=E	<p>Continued From page 22</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to ensure sprinkler heads installed in a compartment were of the same temperature response type, and not obstructed.</p> <p>The findings include:</p> <p>Observations, on 03/19/13 between 9:00 AM and 3:30 PM, with the Maintenance Director revealed sprinkler heads located in the attic above the South Hall to be obstructed by insulation. Further</p>	K 056	<p><u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> The individually-mentioned sprinkler heads have been replaced with a type with the same response rating as the other sprinkler heads in the smoke compartment. Also, sprinkler heads will be replaced with a type so that they are not obstructed, or obstructions will be eliminated where indicated.</p> <p><u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u> All residents have the potential of being equally affected by this deficient practice.</p> <p><u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u> Replacement of the sprinkler heads with the correct type will ensure that the violation does not recur. Annual inspection of the sprinkler system by the sprinkler company will ensure that the system remains in compliance. The Director of Maintenance was made aware of this requirement by the Fire and Safety inspector during the survey, cross-referenced it in the NFPA manual on the same day, and discussed the repair with the sprinkler company. The repair was completed on 4/22/13.</p> <p><u>How the facility plans to monitor its performance to ensure that the solutions are sustained:</u> Annual inspection by the sprinkler company will ensure that the solutions are sustained.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance</p> <p>5-5-13 5-2-13 Ang Johnson Ang PG 5-1-13</p>



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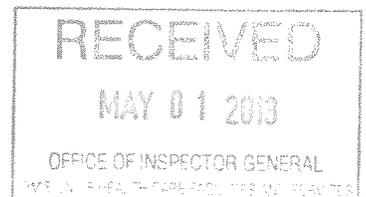
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K 056	<p>Continued From page 23</p> <p>observation revealed mixed response sprinkler heads located in the Hunt Hall Corridor. Further observation revealed sprinkler heads obstructed by light fixtures or other objects on ceiling located in the Laundry Room and Doctors Charting Room.</p> <p>Interview, on 03/19/13 between 9:00 AM and 3:30 PM, with the Maintenance Director revealed he was not aware of the obstructed sprinkler heads or the requirement for sprinkler heads being of the same response rating in a compartment.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation hydraulic design basis, the system area of</p>	K 056	



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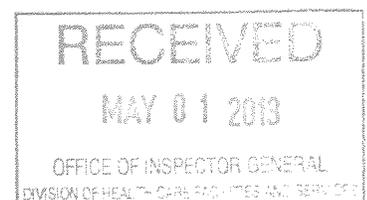
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K 056	<p>Continued From page 24</p> <p>operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type.</p> <p>Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the</p>	K 056	



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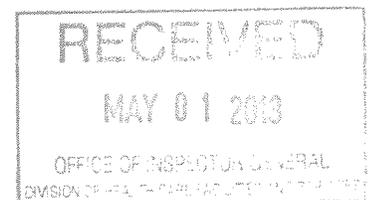
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K 056	<p>Continued From page 25</p> <p>maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type.</p> <p>Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p>	K 056	



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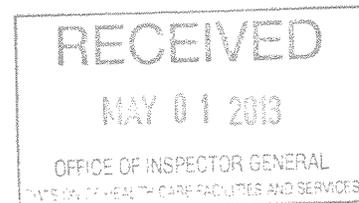
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K 056	<p>Continued From page 26</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 ed.)</p> <p>5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th style="text-align: left;">Maximum Allowable Distance of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
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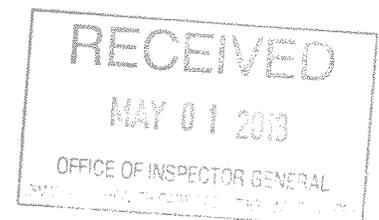
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K 056	Continued From page 27 Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).	K 056			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to complete the required testing for the dry sprinkler system.  The findings Include:  Sprinkler Testing Record Review, on 03/19/13 at 10:55 AM, with the Maintenance Director revealed the facility did not have documentation for the partial trip test being performed on the sprinkler system for the two (2) years in between the full trip test. Further sprinkler testing record review revealed the gauges on the sprinkler riser had not been calibrated or replaced within the last five years.	K 062	<u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> Partial trip testing of the sprinkler system will be performed for each two year period between the full trip test. The sprinkler company (B&B) completed a partial trip test on 4/19/13. B&B also calibrated or replaced on that date. B&B also inspected the entire system to identify any other areas that require maintenance and reported their findings to the Director of Maintenance. <u>How other residents/patients are identified as having the potential to be affected by this deficient practice:</u> All residents have the potential of being equally affected by this deficient practice. <u>Measures put into place or systematic changes made to ensure the deficient practice does not recur:</u> The fire testing company was informed of the need to perform these tests and maintenance of the system on 4/19/13. Compliance of these requirements by the fire testing company, and annual reminders from the Director of Maintenance, will ensure that the violation does not recur. <u>Specific measures utilized to ensure the violation will not recur:</u> Annual inspection and maintenance of the system by B&B will ensure that the system remains in compliance. The QA committee was informed of this Plan of Correction on 4/25/13, and accepted the POC. <u>Person responsible for this correction:</u> Director of Maintenance	5-5-13 5-2-13 mg/hygon by PBS/113	



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K 062	<p>Continued From page 28</p> <p>Interview, on 03/19/13 at 10:55 AM, with the Maintenance Director revealed he was not aware of the requirement.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>9-4.4.2.2.1* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service.</p> <p>9-4.4.2.2.2* During those years when full flow testing in accordance with 9-4.4.2.2.1 is not required, each dry pipe valve shall be trip tested with the control valve partially open.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation, hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure</p>	K 062	



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K 062 Continued From page 29

7-2.3.2.4 when all of the following conditions are satisfied:

- (1) Wet pipe system
- (2) Light hazard or ordinary hazard occupancy
- (3) 20-ft (6.1-m) maximum ceiling height

The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type.

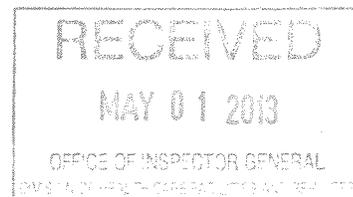
Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.

Reference: NFPA 25 (1998 Edition).

10-2.2\* Obstruction Prevention.  
Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.

10-2.3\* Flushing Procedure.  
If an obstruction investigation carried out in

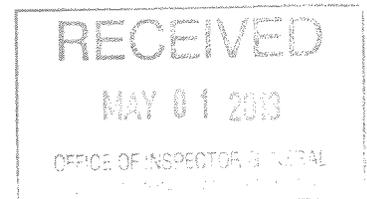
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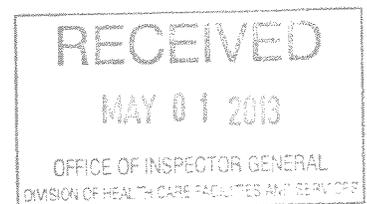
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K 062	<p>Continued From page 30</p> <p>accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="0"> <tr> <td>Item</td> <td>Activity</td> <td>Frequency</td> <td>Reference</td> </tr> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td>2-2.4.1</td> </tr> <tr> <td>Hydraulic nameplate</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.7</td> </tr> <tr> <td>Buildings</td> <td>Inspection</td> <td>Annually (prior to freezing weather)</td> <td>2-2.5</td> </tr> <tr> <td>Hanger/seismic bracing</td> <td>Inspection</td> <td>Annually</td> <td>2-2.3</td> </tr> <tr> <td>Pipe and fittings</td> <td>Inspection</td> <td>Annually</td> <td>2-2.2</td> </tr> <tr> <td>Sprinklers</td> <td>Inspection</td> <td>Annually</td> <td>2-2.1.1</td> </tr> <tr> <td>Spare sprinklers</td> <td>Inspection</td> <td>Annually</td> <td>2-2.1.3</td> </tr> <tr> <td>Fire department connections</td> <td>Inspection</td> <td>Table 9-1</td> <td></td> </tr> </table>	Item	Activity	Frequency	Reference	Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2	Control valves	Inspection	Weekly/monthly	Table 9-1	Alarm devices	Inspection	Quarterly	2-2.6	Gauges (wet pipe systems)	Inspection	Monthly	2-2.4.1	Hydraulic nameplate	Inspection	Quarterly	2-2.7	Buildings	Inspection	Annually (prior to freezing weather)	2-2.5	Hanger/seismic bracing	Inspection	Annually	2-2.3	Pipe and fittings	Inspection	Annually	2-2.2	Sprinklers	Inspection	Annually	2-2.1.1	Spare sprinklers	Inspection	Annually	2-2.1.3	Fire department connections	Inspection	Table 9-1		K 062	
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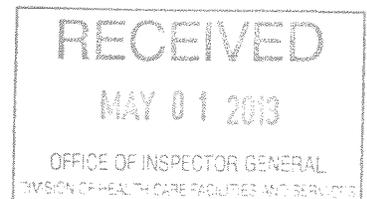
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K 062	<p>Continued From page 31</p> <p>Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2 Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>K 064 SS=D NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p>	K 062	<p>Corrective action(s) accomplished for those residents/patients found to have been affected by this deficient practice: Fire extinguishers have been installed in the exterior designated smoking areas. (complete on April 10, 2013.)</p> <p>5-5-13 6-2-13 Raj H... by PB 6-1-13</p>



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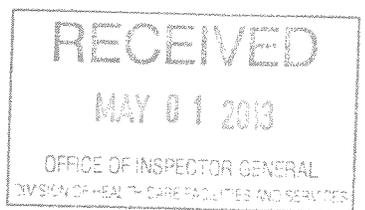
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K 064	<p>Continued From page 32</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff, and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to ensure the designated smoking areas had a fire extinguisher.</p> <p>The findings include:</p> <p>Observation, on 03/19/13 at 2:43 PM, with the Maintenance Director revealed there was no fire extinguisher located in the designated smoking areas.</p> <p>Interview, on 03/19/13 at 2:43 PM, with the Maintenance Director revealed he was not aware that a fire extinguisher was required to be located in the smoking areas.</p> <p>Reference: NFPA 10 1999</p> <p>4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place</p>	K 064	<p><u>How the facility will identify other residents/patients having the potential to be affected by the same deficient practice:</u> All residents have equal potential to be affected by this deficient practice. <u>Measures to be put into place or systematic changes made to ensure that the deficient practice does not recur:</u> The Director of Maintenance will visually inspect the smoking areas on an annual basis to ensure that the fire extinguishers are still in place and to test and tag them along with the other extinguishers in the facility. <u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> These extinguishers will be checked monthly for continued operation and will receive immediate corrective action should an issue arise. <u>Person responsible for this correction:</u> Director of Maintenance</p>	



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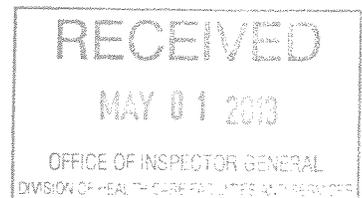
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 064	Continued From page 33 (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.	K 064	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	<u>Corrective action(s) accomplished for those residents/patients found to have been affected by this deficient practice:</u> Metal containers with self-closing lids have been purchased and placed in the designated, exterior, smoking areas for the purpose of dumping the contents of the ashtrays. (Done April 10, 2013). <u>How the facility will identify other residents/patients having the potential to be affected by the same deficient practice:</u> All residents have equal potential to be affected by this deficient practice. <u>Measures to be put into place or systematic changes made to ensure that the deficient practice does not recur:</u> Ashtrays will be emptied daily into the metal containers and the containers emptied into the trash bin when needed. Smoking  5-5-13 5-2-13 <i>Angela Johnson</i> by RB 5-1-13



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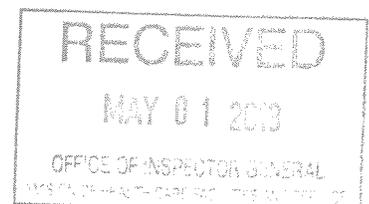
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K 066	<p>Continued From page 34</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.</p> <p>The findings include:</p> <p>Observation, on 03/19/13 at 2:43 PM, with the Maintenance Director revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas.</p> <p>Interview, on 03/19/13 at 2.43 PM, with the Maintenance Director revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4 Smoking (4)</p>	K 066	<p>materials in the cans will be checked for non-combustion before emptying.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u></p> <p>The Director of Maintenance will check the smoking areas on a monthly basis to ensure that the metal containers are being used properly in those areas. If it is found that the containers are not being used properly, staff will be instructed on their proper use. If the containers are missing from their location for any reason, new containers will be purchased and placed in the smoking areas.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance</p>	



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K 066	Continued From page 35 Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey.  The findings include:  Observation, on 03/19/13 at 2:05 PM, with the Maintenance Director revealed a portable space heater located in the Staffing Office and the Unit Secretary Office. The facility failed to ensure the heaters did not exceed 212 degrees.  Interview, on 03/19/13 at 2:05 PM, with the Maintenance Director revealed he was not aware the heaters element could not exceed 212°F in	K 070	<u>Corrective action(s) accomplished for those residents/patients found to have been affected by this deficient practice:</u> All portable heaters in the facility were on 3/25/13 tested with an infrared thermometer by the Director of Maintenance to ensure that any in service do not exceed 212 degrees F. (100 degrees C.) Any heaters found to not be in compliance will be removed from service. <u>How the facility will identify other residents/patients having the potential to be affected by the same deficient practice:</u> All residents have equal potential to be affected by this deficient practice. <u>Measures to be put into place or systematic changes made to ensure that the deficient practice does not recur:</u> Any new heaters brought into the facility will be tested to ensure that they meet the 212 degree F. maximum temperature standard. The Director of Maintenance was educated regarding this requirement on 3/24/13 by the surveyor and cross-referenced in the NFPA manual. <u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> Any new heaters brought into the facility will be checked by the Director of Maintenance for compliance. <u>Person responsible for this correction:</u> Director of Maintenance	5-5-13 5-2-13 <i>pn g/kyg</i> by PB 5-1-13





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K 073	Continued From page 37 staff had been treated with a flame retardant material.  Interview, on 03/19/13 at 1:49 PM, with the Maintenance Director revealed he was not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.  Reference: NFPA 101 (2000 Edition)  19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.  K 104 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.  This STANDARD is not met as evidenced by: Based on fire damper testing record review, and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to provide documentation that the smoke/fire dampers were tested within the last four (4) years.  The findings include:	K 073	Documentation will be place on each item by the maintenance department. The Director of Maintenance was aware of this requirement, but the policy had not been followed by the housekeeping department. The housekeepers were educated by the administrator by memo on 4/26/13. <u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> Dir. of Maintenance to check monthly. And report to the QA committee. <u>Person responsible for this correction:</u> Director of Maintenance  K 104 <u>Corrective action(s) accomplished for those residents/patients found to have been affected by this deficient practice:</u> A testing company (A-Tech mechanical) was contacted 4/5/13 regarding testing of the fire/smoke dampers. The dampers were tested on 4/8/13 and placed on a routine schedule to test them every 4 years. Testing will also be placed on a preventative maintenance schedule. <u>How the facility will identify other residents/patients having the potential to be affected by the same deficient practice:</u> All residents have equal potential to be affected by this deficient practice. <u>Measures to be put into place or systematic changes made to ensure that the deficient practice does not recur:</u> Including the testing on a preventative maintenance schedule will ensure that they are operating properly and the violation will not recur.

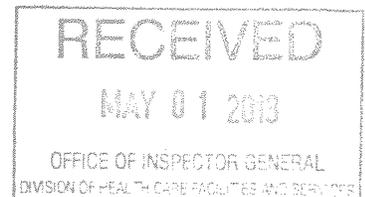
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by PB  
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K 104	Continued From page 38  Fire damper testing record review, on 03/19/13 at 11:15 AM with the Maintenance Director revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years.  Interview, on 03/19/13 at 11:15 AM, with the Maintenance Director revealed he was not aware of the requirements for fire/smoke damper testing.  Reference: NFPA 101 (2000 Edition)  8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions:	K 104	<u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> Quarterly checking of the dampers will be performed by the Director of Maintenance <u>Person responsible for this correction:</u> Director of Maintenance.



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K 104 Continued From page 39

a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.

b. It shall be protected by an approved device that is designed for the specific purpose.

(3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:

a. It shall be made on either side of the smoke barrier.

b. It shall be made by an approved device that is designed for the specific purpose.

8.3.6.2

Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions:

(1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier.

(2) It shall be protected by an approved device that is designed for the specific purpose.

Reference: NFPA 90A (1999 edition)

3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.

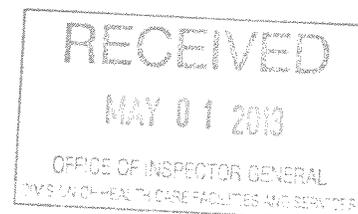
K 144 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

K 104

K 144 Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:  
The facility's generator maintenance company (Cummins Cross Point) was contacted 4/5/13 and Advantage Electric on 4/5/13 to install a new panel so that transfer power times can

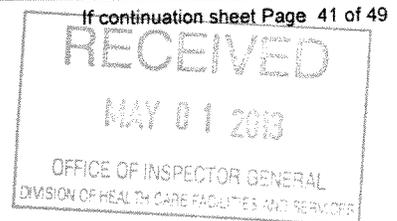
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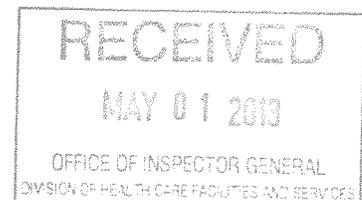
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K 144	Continued From page 40  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey.  The findings include:  Observation, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed the facility did not document the time it takes for the generator to transfer power in the event of a power interruption. Further observation revealed the facility failed to provide a remote annunciator for the generator.  Interview, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed he was not aware the transfer time was to be documented. Further interview revealed he thought the facility had a remote annunciator; however the panel only showed if the generator was running.	K 144	be recorded as part of the routine testing of the generator. Also, a remote annunciator for the generator will be installed in the facility's common area. This will be completed by May 5, 2013. <u>How other residents/patients having the potential to be affected by the same deficient practice are identified:</u> All residents have equal potential to be affected by this deficient practice. <u>Measure put in place of systematic changes made to ensure that the deficient practice does not recur:</u> The installation of the new panel and annunciator light will ensure that this violation does not recur. The maintenance department will receive training from the company following installation of the new panel and annunciator. <u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> Each test's results will be recorded on a log and stored in the maintenance dept. office. <u>Person responsible for this correction:</u> Director of Maintenance	



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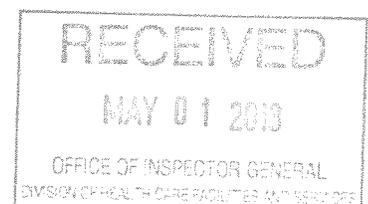
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K 144	<p>Continued From page 41</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]</p>	K 144		



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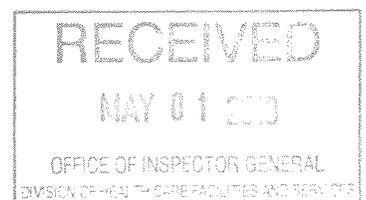
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K 144	Continued From page 42  Reference: NFPA 110 (1999 Edition).  5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.  Reference: NFPA 99 (1999 Edition)  Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.	K 144	



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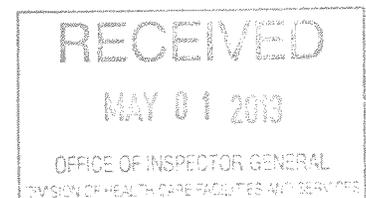
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K 144	<p>Continued From page 43</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3-3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p>	K 144		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD SS=E	K 147		



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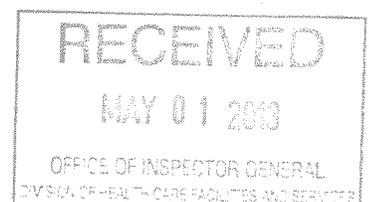
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/20/2013
NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219	
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K 147	<p>Continued From page 44</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff, and visitors. The facility is certified for sixty eight (68) beds with a census of sixty three (63) on the day of the survey. The facility failed to maintain proper use of power strips and extension cords.</p> <p>The findings include:</p> <p>Observations, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> <li>1) A refrigerator was plugged into a power strip located in the Therapy Room.</li> <li>2) An extension cord was plugged into a power strip located in the Therapy Room.</li> <li>3) A microwave was plugged into an extension cord located in the Medical Records Office.</li> <li>4) A refrigerator, microwave, and coffee maker were plugged into a multi-plug adaptor located in the Staffing Office.</li> <li>5) Lift battery chargers were plugged into a power strip located in the CNA Charting Room.</li> <li>6) An extension cord located in the Staff Development Coordinators Office.</li> </ol>	K 147	<p><u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> Usage of extension cords and power strips will be assessed in the facility and any inappropriate use will be discontinued. The cords identified during the survey have been removed, and/or appliances taken out of service. Affected staff have been instructed to NOT use extension cords, and power strips cannot be used with microwaves and refrigerators.</p> <p><u>How other residents/patients having the potential to be affected by the same deficient practice are identified:</u> All residents have equal potential to be affected by this deficient practice.</p> <p><u>Measure put in place of systematic changes made to ensure that the deficient practice does not recur:</u> The Director of Maintenance will inspect the facility on a monthly basis and remove any extension cords found to be in use.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> The Director of Maintenance, during his monthly lighting check, will also monitor for extension cord usage, and remove any found to be in use.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance</p> <p>5-5-13 5-2-13 m g h 67 PB 5-1-13</p>



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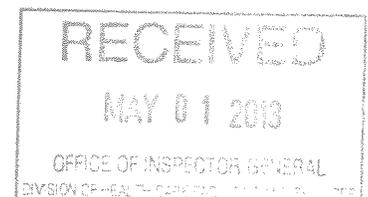
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K 147	<p>Continued From page 45</p> <p>7) A vending machine was plugged into a multi-plug adaptor located in the vending area.</p> <p>Interview, on 03/19/13 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed he was not aware the misuse of power strips and extension cords.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	



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K 147	Continued From page 46 Reference: NFPA 70 (1999 edition)  Reference: NFPA 70 (1999 edition)  370.28(c) Covers.  All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.  Reference: NFPA 101 (2000 Edition)  9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.  Reference: NFPA 70 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		



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K 154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This STANDARD is not met as evidenced by: Based on interview and facility policy and procedure review, this facility failed to develop a fire watch policy in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility has sixty eight (68) beds with a census of sixty three (63) on the day of the survey.</p> <p>The findings include:</p> <p>Policy and Procedure review, on 03/19/13 at 11:07 AM, with the Maintenance Director revealed the facility failed to provide a written policy outlining an approved fire watch system in the event the fire alarm system or the sprinkler system is shut down for four (4) or more hours in a twenty four (24) hour period.</p> <p>Interview, on 03/19/13 at 11:07 AM, with the Maintenance Director revealed he was not aware the facility did not have an approved fire watch</p>	K 154	<p><u>Corrective action(s) to be accomplished for those residents/patients found to have been affected by the deficient practice:</u> In any situation whereby the fire alarm system or the sprinkler system is out of service for more than 4 hours, an employee will be assigned to exclusively check the facility for fire system(s) are once again functional.</p> <p><u>How other residents/patients having the potential to be affected by the same deficient practice are identified:</u> All residents have equal potential to be affected by this deficient practice.</p> <p><u>Measure put in place of systematic changes made to ensure that the deficient practice does not recur:</u> A policy has been written and implemented and appropriate staff educated so that the policy of providing for a fire watch is conducted.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions are sustained:</u> The administrator has educated the Maintenance Director on March 25, 2013 regarding the NFPA requirement. Staff was told of the Policy by the administrator on April 9, 2013.</p> <p><u>Person responsible for this correction:</u> Director of Maintenance</p>	<del>5-5-13</del>



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K 154	<p>Continued From page 48 policy.</p> <p>Reference, NFPA 101 (2000 edition) 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.</p> <p>Reference, NFPA 101 (2000 edition) 9.6.1.8* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p>	K 154	

